DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Medical Assistance Administration
Olympia, Washington

To:	Hospitals Managed Care Plans	**Memorandum No.: 04-76 MAA** **Issued:** October 22, 2004
From:	Douglas Porter, Assistant Secretary Medical Assistance Administration (MAA)	**For Information Contact:** 1-800-562-6188

Subject: Termination of the 24-hour Rule, HCPCS Code Usage and Guidelines, OPPS Implementation, Fee Schedule Changes, and Revenue Code Grid Updates

Effective for dates of service on and after November 1, 2004, the Medical Assistance Administration (MAA) will:

- Terminate the 24-hour rule; and
- Implement the Outpatient Prospective Payment System (OPPS).

This memorandum also includes:

- Billing guidelines;
- A new OPPS fee schedule;
- A revised Outpatient Hospital fee schedule for the Outpatient Hospital Billing Instructions;
- A revised Revenue Code grid; and
- A revised Definitions section for the Outpatient Hospital Billing Instructions.

Termination of 24-hour Rule

Effective for dates of service on and after November 1, 2004, the Department of Social and Health Services (DSHS) will no longer use the "twenty-four hours or less" criteria for hospital admissions as previously defined by DSHS. To bring MAA's policies in line with healthcare industry standards and promote administrative simplicity for providers, MAA will determine the appropriateness of an inpatient admission using medical criteria rather than "twenty-four hours or less" criteria. MAA is currently using InterQual ISD® criteria as the benchmark for determining severity of illness and intensity of service.

General Billing Guidelines

Providers must bill MAA for outpatient hospital services the same way they bill Medicare for similar services.

HCPCS and Revenue Code Usage and Guidelines

Services identified by HCPCS codes have applicable rules and limitations.

These rules and limitations are currently published in:

- MAA's current Physician-Related Services Billing Instructions. Look in these billing instructions for specific information on HCPCS code-related rules including:

  - ✓ Allowable ICD-9-CM diagnosis codes;
  - ✓ Procedure code combinations; and
  - ✓ Provider limitations; and

- MAA's OPPS fee schedule in MAA's current Outpatient Hospital Services Billing Instructions. Look in this fee schedule for specific information on HCPCS codes, including:

  - ✓ Covered;
  - ✓ Non covered; and
  - ✓ Unit limitations.

MAA will incorporate the above mentioned rules and limitations in future editions of MAA's Outpatient Hospital Billing Instructions. MAA is currently revising these billing instructions and will publish them as soon as possible.

Billing Units of Service

Please bill MAA for the actual units of service provided, regardless of whether MAA's allowed number of units is met or exceeded. Claims must accurately reflect the number of actual units provided along with the appropriate revenue codes and procedure codes. MAA does not penalize you for reporting services provided above the allowed amount.

MAA appreciates your input on these limits. If you disagree with MAA's allowed amounts, please send a fax to: 360-753-9152, ATTN: OPPS Program. Be specific about which codes relate to the allowed amounts you would like evaluated as well as a suggestion as to what a reasonable allowed amount would be. Also, please provide rationale for your recommendation. MAA will periodically make changes to the limits as a result of provider comments and will notify providers of changes via MAA's OPPS website.

HCPCS Codes

MAA limits payment to one line of a claim when a HCPCS code is billed in conjunction with more than one revenue code for a single date of service. **Exception:** Physical and Occupational Therapy (revenue codes 042X and 043X) may both be billed on a single date of service in conjunction with the same HCPCS code.

For dates of service on and after December 1, 2004, MAA will no longer cover CPT code 36415. Use CPT code G0001.

Attached to this memorandum is the new Outpatient Hospital Fee Schedule.

Revenue Code Grid Changes

MAA made several changes to the revenue code grid to allow Medicare compliant billing and to enhance provider reimbursement under the OPPS methodology. **Effective for dates of service on and after December 1, 2004,** MAA will no longer cover the following revenue codes.

Non-covered Revenue Code	Suggested Revenue Code
0500	N/A
0760	Use either 0761 or 0762

Attached to this memorandum is a revised Revenue Code Grid.

Implementation of the Outpatient Prospective Payment System (OPPS)

What is OPPS? **[Refer to WAC 388-550-7000]**

MAA's outpatient prospective payment system (OPPS) uses an ambulatory payment classification (APC) based reimbursement methodology as its primary reimbursement method. MAA has modeled its OPPS after the Centers for Medicare and Medicaid Services (CMS) Prospective Payment System for Hospital Outpatient Department Services, to pay certain hospitals for covered outpatient services provided to Medical Assistance clients.

For a complete description of the CMS outpatient hospital prospective payment system, see 42 CFR, Chapter IV, Part 419, et al. The Code of Federal Regulations (CFR) is available at http://www.gpoaccess.gov/cfr/index.html.

CPT is a trademark of the American Medical Association.
CPT codes and descriptions are copyright 2003 American Medical Association.

Who is exempt from OPPS? **[Refer to WAC 388-550-7100]**

MAA exempts the following hospitals from the initial implementation of MAA's OPPS:

- Cancer hospitals;
- Critical access hospitals;
- Free-standing psychiatric hospitals;
- Out-of-state hospitals (border-area hospitals are considered in-state hospitals);
- Pediatric hospitals;
- Peer group A hospitals;
- Rehabilitation hospitals; and
- Veterans' and military hospitals.

Payment Method Determination **[Refer to WAC 388-550-7200]**

MAA's payment method will be determined by which HCPCS code is on the claim line(s). MAA will pay OPPS hospitals using the following methods in the following order:

- The APC method is used to pay for covered services for which CMS has established an APC weight or a national payment rate.

- The fee schedule is used to pay for covered services for which there is no established APC weight or nationwide payment rate and for services exempted from APC payment.

- The hospital outpatient rate, as described in WAC 388-550-4500, is used to pay for the covered services for which neither an APC weight, a nationwide payment rate, or a fee has been established.

See MAA's OPPS fee schedule for a list of all procedures and their associated fees. This fee schedule is available on MAA's website at: http://maa.dshs.wa.gov/HospitalPymt/Inpatient/PPSHospital.htm.

Payment Limitations **[Refer to WAC 388-550-7300]**

MAA does not make a separate payment for services that are packaged into the APC rates.

OPPS Payment Calculation **[Refer to WAC 388-550-7600]**

MAA follows CMS's discounting and modifier policies and calculates the APC payment as follows:

APC payment =
APC relative weight x OPPS conversion factor x
Discount factor (if applicable) x Units of service (if applicable) x
Budget target adjustor

The total OPPS claim payment is the sum of:

- The APC payments; and
- The lesser of billed charges or allowed charges for all non APC services.

Observation Services

- MAA reimburses separately for observation services when:

  - ✓ They are medically necessary for eight hours or more and
  - ✓ Both the ICD-9-CM diagnosis code and HCPCS code are covered by MAA.

- MAA does not use Medicare's observation diagnosis list or diagnostic test requirements to restrict payment for observation services.

Denied Lines

If MAA has denied a line of service in error, the entire claim must be adjusted. MAA will not allow single line adjustments for OPPS providers.

Definitions

MAA has added new OPPS-specific definitions to the Outpatient Hospital Billing Instructions. Attached to this memorandum is a revised Definitions section for MAA's Outpatient Hospital Billing Instructions.

About the OPPS Fee Schedule

This fee schedule is intended to supply hospital providers with coverage, rate, and unit limitation information for services provided in a hospital and billed on a hospital claim. This document does not attempt to relay the policies of the specific programs that govern the service. Please see the program-specific publications for authorization, client, and service eligibility information.

Billing Instructions Replacement Pages

Attached are replacement pages 1-6, E.1-E.24, and F.1-F.48 for MAA's current Outpatient Hospital Billing Instructions.

How can I get HRSA's provider issuances?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Definitions

This section defines terms and acronyms used in these billing instructions. Please refer to MAA's General Information Booklet for other definitions.

Alcoholism & Drug Addiction Treatment & Support Act (ADATSA) - The law and a state-funded program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.

Alternative Outpatient Payment - A payment calculated using a method other than the ambulatory payment classification (APC) method, such as the outpatient hospital rate or the fee schedule. [Refer to WAC 388-550-7050]

Ambulatory Payment Classification (APC) - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed. [Refer to WAC 388-550-7050]

Ambulatory Payment Classification (APC) Weight - The relative value assigned to each APC. [Refer to WAC 388-550-7050]

Ambulatory Payment Classification (APC) Conversion Factor - A dollar amount that is one of the components of the APC payment calculation. [Refer to WAC 388-550-7050]

Assignment - A process in which a doctor or supplier agrees to accept the Medicare program's payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Authorization Requirement – MAA's requirement that a provider present proof of medical necessity evidenced either by obtaining a prior authorization number or by using the expedited authorization process to create an authorization number.

Authorization Number - A nine-digit number, assigned by MAA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Budget Target – The amount of money appropriated by the legislature or through MAA's budget process to pay for a specific group of services including anticipated case load changes or vendor rate increases. [Refer to WAC 388-550-7050]

Budget Target Adjustor - The MAA specific multiplier applied to all payable ambulatory payment classifications (APCs) to allow MAA to reach and not exceed the established budget target. [Refer to WAC 388-550-7050]

Bundled Services – Interventions that are integral to the major procedure and are not reimbursable separately.

By Report (BR) – A method of reimbursement in which MAA determines the amount it will pay for a service when the rate for that service is not included in MAA's published fee schedules. The provider must submit a "report" upon request that describes the nature, extent, time, effort and /or equipment necessary to deliver the service.

Carrier – The private organization (usually insurance companies) that has a contract with Health Care Financing Administration (HCFA) to review, approve or deny claims, then process the payment for Medicare Part B (medical insurance).

Client – A person who receives or is eligible to receive services through DSHS.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Coinsurance - The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20% of reasonable charges.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement – A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medical Assistance program.

Current Procedural Terminology (CPT) – A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

Deductible – The amount a beneficiary is responsible for, before Medicare starts paying; or the initial specific dollar amount for which the applicant or client is responsible.

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Diagnosis Related Group (DRG) – A classification system that categorizes hospital inpatients into clinically coherent and homogenous groups with respect to resource use, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions. Classification of patients is based on the International Classification of Diseases (ICD-9), the presence of a surgical procedure, patient age, presence or absence of significant complications or co-morbidities, and other relevant criteria.

Discount Factor - The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor. [Refer to WAC 388-550-7050]

Emergency Services – Medical services required by and provided to a patient after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

For hospital reimbursement purposes, inpatient maternity services are treated as emergency services.

Expedited Prior Authorization - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Expedited Prior Authorization Number – An authorization number created by the provider that certifies that MAA's published criteria for the service, supply, or equipment have been met.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to medical assistance clients.

Hospital - An entity which is licensed as an acute care hospital in accordance with applicable state laws and regulations, and which is certified under Title XVIII of the federal Social Security Act.

ICD-9-CM (International Classification of Diseases, 9th Revision Clinical Modification Edition) – The systematic listing that transforms verbal descriptions of diseases, injuries, conditions and procedures into numerical or alphanumerical designations (coding).

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable Fee (MAF) - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services (DSHS) authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards or medical coupons.

Medical Management Information System (MMIS) – The systems, structures, and programs that MAA uses to process medical claims.

Medical visit - Diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting. [Refer to WAC 388-550-7050]

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts – Part A and Part B.

"Part A" does not apply to Inpatient Hospital Services.

"Part B" is that part of the Medicare program that helps pay for, but is not limited to:

- Physician services;
- Outpatient hospital services;
- Diagnostic tests and imaging services;
- Outpatient physical therapy;
- Speech pathology services;
- Medical equipment and supplies;
- Ambulance;
- Mental health services; and
- Home health services.

Modifier - A two-digit alphabetic and/or numeric identifier that is added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules. [Refer to WAC 388-550-7050]

Observation services - Services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient. [Refer to WAC 388-550-7050]

Outpatient – A client who is receiving medical services in other than an inpatient hospital setting.

Outpatient Care – Medical care provided other than inpatient services in a hospital setting.

Outpatient code editor (OCE) - A software program published by 3M Health Information Systems that MAA uses for classifying and editing claims in ambulatory payment classification (APC) based OPPS. [Refer to WAC 388-550-7050]

Outpatient Hospital – A hospital authorized by DSHS to provide outpatient services.

Outpatient prospective payment system (OPPS) - The payment system used by MAA to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment. [Refer to WAC 388-550-7050]

Pass-throughs - Certain drugs, devices, and biologicals, as identified by Centers for Medicare and Medicaid Services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC). [Refer to WAC 388-550-7050]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client and consists of:

a) First and middle initial (or a dash [-] must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters/characters of the last name (use spaces if the last name is fewer than five letters or use a hyphen for hyphenated last names).
d) Alpha or numeric character (tiebreaker).

Plan of Treatment/Care – The written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale for services ordered.

Principal Diagnosis - The medical condition determined, after study of the patient's medical records, to be the principal cause of the patient's hospital stay.

Principal Procedure - A procedure performed for definitive treatment, not for diagnostic, exploratory, or in treating a complication.

Prior Authorization – Approval required from MAA prior to providing certain medically necessary services, items, or supplies. ***Expedited prior authorization and limitation extensions are types of prior authorization.***

Provider or Provider of Service - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Provider Number – A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with MAA.

Remittance And Status Report (RA) - A report produced by the claims processing system in the MAA's Division of Program Support that provides detailed information concerning submitted claims and other financial transactions.

Revenue Code – A nationally assigned 3-digit coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

Revised Code of Washington (RCW) - Washington State laws.

Selective Contracting Area (SCA) - An area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by MAA patients.

Short Stay - See "Outpatient Care."

SI - See **"Status Indicator."** [Refer to WAC 388-550-7050]

Significant procedure - A procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional. [Refer to WAC 388-550-7050]

Spenddown – The process of assigning excess income for the Medically Needy Program (MNP), or excess income and/or resources for the Medically Indigent Program (MIP), to the client's cost of medical care. The client must incur medical expenses equal to the excess income (spenddown) before medical care can be authorized. ***(This definition is for hospitals only.)***

Status indicator (SI) - A one-digit identifier assigned to each service by the outpatient code editor (OCE) software. [Refer to WAC 388-550-7050]

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Transfer – To move a client from one acute care facility or distinct unit to another acute care facility or distinct unit.

UB-92 – The uniform billing document intended for use nationally by hospitals, non-hospital Level B acute PM&R nursing facilities, home health, and hospice agencies.

Usual & Customary Charge – The charge customarily made to the general public for a procedure or service, or the rate charged other contractors for the service if the general public is not served.

Washington Administrative Code (WAC) Codified rules of the State of Washington.